BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

CYNTHIA J. MODNY, M.D.

Holder of License No. **22577**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case Nos. MD-05-0341A
MD-05-0434A
MD-05-0701A
MD-05-0702A
MD-05-0703A
MD-05-0704A
MD-05-0705A
MD-05-1062A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER
(Letter of Reprimand and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on December 7, 2006. Cynthia J. Modny, M.D., ("Respondent") appeared before the Board with legal counsel D. Jay Ryan for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 22577 for the practice of allopathic medicine in the State of Arizona.

CASE MD-05-0341A

3. The Board initiated case number MD-05-0341A after receiving a complaint regarding Respondent's care and treatment of a forty-four year-old female patient ("SO"). SO presented to Respondent on February 3, 2005 for a mole check and complete body screen. Respondent's record for the February 3 examination states SO complained of a mole, Respondent checked the mole and performed a full-body check. There is no identifiable

examination in the record. Respondent's assessment and plan noted "1) right mid back dysplastic nevus, pt. Refused Rx 20 one other dysplastic nevi, 3) [illegible] nevi, [illegible] complete skin [illegible] performed." Another note on the chart, written in another person's hand and signed "BN," states SO is not going to return. SO completed a medical history form that includes a chief complaint of "skin check," lists her medications, her allergies, her surgical procedures, and a check list of any prior diseases she may have had. SO was charged CPT Code 99203 for this visit.

4. Prior to her visit, SO was given and signed a form letter that she was not to wear any fragrances or organic solvent products to Respondent's office. SO complained that: she presented to the visit after showering and did not apply skin lotion, deodorant, hairspray or perfume; when she was brought to the examining room a sliding glass door to the exterior of the building and the curtains for the door were open; SO asked Respondent's staff to close the door, but was told "no" because the staff person smelled something on her; SO was handed a paper gown and asked to undress to her underwear; SO asked the staff person to at least close the curtain for some privacy and the curtain was closed; Respondent came into the examination room and her assistant immediately opened the curtain; the examination room faced a busy street; Respondent performed a skin cancer screening that lasted approximately thirty seconds; SO informed Respondent she had not been made aware of her allergy until her appointment reminder call she received the day before; Respondent replied that everyone was told but "some people just don't listen;" Respondent stated her allergies were serious and that is why she was wearing a surgical mask; and SO was concerned about her physical safety because there was nothing to prevent a person from entering the examination room through the sliding door and the bushes on either side of the door could have provided a concealed space for a person to hide.

MD-05-0434A

5. The Board initiated case number MD-05-0434A on July 5, 2005 after receiving a complaint regarding Respondent's care and treatment of a fifty-nine year-old woman ("JS"). JS presented to Respondent on March 29, 2005 for a complete skin examination and complaints of red spots on her back and right arm, a spot on the right posterior thigh, and a cyst on the scalp. Respondent's chart contains no detailed history of present illness or review of systems and no physical examination is documented, except that Respondent comments "skin exam total performed." Respondent did not document any findings from the total skin examination she documented as having performed. In the assessment and plan Respondent noted "1&2) right upper arm and mid upper back – R/O SCC both shave bx 1.5." The medical history form completed by JS notes her chief complaint, current medications, allergies, past surgical history, past diseases she might have had and social history. A pathology report prepared by Respondent on March 29, 2005 reports specimen A and B both revealed basal cell carcinoma. JS was charged CPT Code 99203 in addition to the codes for removal of the lesions.

6. JS also complained about Respondent's rude behavior during the visit. According to JS she, and her husband who had a visit on the same day, were advised by Respondent's staff not to wear perfume or men's cologne or hairspray; when JS checked in for the visit she informed Respondent's staff she was not wearing hairspray or perfume, but did have mousse in her hair; JS was then asked whether her or her husband's clothing had fabric softener on them, JS said they did; when Respondent first presented to examine JS she told JS she was going to leave the examination room door open and air the room out; Respondent did not explain anything she was doing when she performed a biopsy; and was very rude in telling JS she could call in a week for the biopsy results.

MD-05-0701A

7. The Board initiated case number MD-05-0701A in July 2005 after receiving a complaint regarding Respondent's care and treatment of a forty-two year-old female patient ("LK"). LK presented to Respondent on June 30, 2005 for evaluation of a right upper arm lesion. There is no office note for this visit other than the medical history form filled out by LK. The diagnosis codes circled on the charge sheet indicate Respondent made three diagnoses: "1) Cyst, 2) Dyschomia, 3) Lentigo, Solar." LK was charged CPT Code 99203 for this visit in addition to codes for shave excision, and surgical pathology specimen and supplies.

8. LK complained that she had no prior knowledge of Respondent's allergies before arriving for her visit; she informed Respondent's staff she and her son, who had accompanied her, were wearing sunscreen and hair gel; Respondent's staff required her son to wash the hair gel out of his hair; Respondent left a sliding glass door wide open to the exterior of the building during her examination; Respondent performed a biopsy of her arm without offering any explanation and did so with the exterior door wide open; and that Respondent was rude.

MD-05-0702A

9. The Board initiated case number MD-05-0702A in July 2005 after receiving a complaint regarding Respondent's care and treatment of a forty-two year-old female patient ("BL"). BL presented to Respondent on June 11, 2003, December 10, 2003, March 31, 2004 and September 9, 2004 for various skin complaints. On her initial June 11, 2003 visit BL was charged CPT Code 99203 and charged for a destruction of a lesion. Respondent's office note for this visit indicates a chief complaint of peeling feet – itchy spots on right arm and complete body check. Respondent did not document any detailed history of present illness or review of systems. Respondent did not document any identifiable examination. Respondent's assessment and plan notes "10 peeling dorsum feet – Diprivan QID, 2) AK – R arm – [LN #1], 3) Lentigo [illegible], Seb K; new, leg."

10. BL's complaint stated she had been informed of Respondent's allergies/sensitivities and wore no cologne or hair spray, used fragrance-free lotion and fragrance-free deodorant, and wore a new linen outfit so there was no residue from wearing it in the past; when she was taken to an examination room Respondent's staff left open the exterior sliding door that was open when they entered the room; when BL asked why the door was being left open on a warm day she was told it was because Respondent's staff could smell something on her; when Respondent entered the room BL asked that the door be closed, but Respondent refused, because she detected a fragrance; BL was uncomfortable and perspiring; BL explained how considerate she had been of Respondent's condition and what she had done for the appointment (no scents, etc.) and Respondent informed her the smell was probably the formaldehyde in her new outfit; and Respondent was rude.

CASE MD-05-0703A

11. The Board initiated case number MD-05-0703A in July 2005 after receiving a complaint regarding Respondent's care and treatment of a forty-one year-old female patient ("BG"). BG presented to Respondent on May 19, 2005. Respondent's record reflects a chief complaint and history and physical of "c/o acne, dry rough face and declined body check." Respondent did not document any history of present illness, review of symptoms, or physical examination. Respondent's assessment and plan indicates BG has mild papular acne on the face. Respondent offered the treatment options of Retin-A, Kinerase and ATS solution, Azelex cream and Triaz gel, all BID. Respondent also told BG to use Tone soap. On this same note a May 24, 2005 phone call from BG is documented in different handwriting stating BG was canceling her July appointment and filing a complaint with the Board. BG was charged CPT Code 99203.

12. BG's complaint stated: when she made her appointment with Respondent the receptionist informed her Respondent was allergic to scented products and asked BG to not wear

any hairspray, hair gel, or scented lotions/perfumes; BG was not informed not to wear clothing that had been dry cleaned; when BG presented for her visit she was provided the form stating she was not to wear any fragrances or organic solvent products in Respondent's office; BG did not wear hairspray, gel or scented products, but did wear clothing that had come back from the dry cleaner; BG signed the form and circled "dry cleaning" to indicate she was wearing clothing that had been dry cleaned; she was asked to remove all of her clothing, including her underwear, and place it in a plastic garbage bag and was given a paper gown; BG had rejected the offer of a body examination and reiterated she was there for an examination for facial acne; Respondent came into the examination room wearing a surgical mask; and Respondent was rude.

Case Number MD-05-0704A

13. The Board initiated case MD-05-0704A in July 2005 after receiving a complaint regarding Respondent's care and treatment of a seventy-two year-old female patient ("VR"). VR presented to Respondent on several occasions. VR's initial visit was on October 20, 2004 after being referred by another physician for a spot on the right tibia and a total body check. Respondent's chart contains no detailed history of present illness, review of systems, or physical examination. Respondent's assessment and plan indicates she performed shave biopsies of 1.5 cm each of the right mid leg, left posterior lateral leg, and left upper arm. Respondent also noted a nevi, lentigo, sebK and cyst, but did not identify the locations. Respondent planned a follow-up in one year. An October 20, 2004 pathology report revealed basal cell carcinoma, superficial multi-focal type extending from the lateral margin and left posterior lower leg biopsy with inflamed squamous papule with features of seborrheic keratosis and skin left upper arm biopsy revealing lichen planus-like keratosis. Respondent saw VR again on November 10, 2004 for right medial lower leg basal cell excision. A November 10, 2004 pathology report revealed no basal cell carcinoma. VR presented for a visit on May 23, 2005, but there was no referral from her primary care physician. VR was provided with the form letter that she was not to wear any fragrances or

organic solvent products to Respondent's office. VR was told she could pay on a cash basis to see Respondent that day, but VR declined.

Case Number MD-05-0705A

14. The Board initiated case MD-05-0705A in July 2005 after receiving a complaint regarding Respondent's care and treatment of a thirty year-old female patient ("JK"). JK presented to Respondent on June 15, 2005 for a complete skin examination. Respondent's office visit note includes a chief complaint of "30 y.o. female with sunspots. Complete skin exam." Respondent noted JK's history as being afraid of needles. The medical history form completed by JK includes her chief complaint of "growths from sun damage," her medications, allergies, and surgical procedures. Respondent's chart contains no identifiable physical examination or review of systems. Respondent's chart contains an assessment and plan of "1&2) R and L upper arm – [illegible] sebks R/O SCC. Both Shave bx 1.5, 3) L pretibial area – sebK – ok, and 4) R forearm – sebK – ok." A pathology report from June 15, 2005 completed by Respondent reports a microscopic diagnosis of A) SEB K and B) SEB K. Respondent did not document a formal procedure note. In another person's handwriting on the same page, but dated July 6, 2005, is the following note "Pt has filed a complaint to Cigna and AZ medical board, per Jan at Cigna." JK was charged CPT Code 99203.

15. JK's complaint states she was informed before her appointment that Respondent was allergic to solvents and was careful to follow the instructions, even wearing an outfit that had not been treated with fabric softener; JK did wear a small amount of hairspray because she was going to work after her appointment and Respondent was going to be looking at her arms; JK was placed in an examination room and the sliding door to the exterior was left open; JK was asked to put on a surgical hat to cover her hair; when Respondent came into the examination room she was in a rush and quickly looked at the four spots JK was concerned with and said two of them were aggravated and needed biopsies; and Respondent was rude and abusive.

Case Number MD-05-1062A

16. The Board initiated case number MD-05-1062A in October 2005 after receiving a complaint that Respondent failed to provide for the comfort and security of a fifty-seven year-old female patient "(MK"). MK had an October 11, 2005 appointment with Respondent. Respondent's chart notes "+ hair spray" and "+ perfume" and "B spoke to." Next to the review of systems the record reads "1) angio 2 lip [illegible] ok, 20 L arm – [illegible] c/ cyst – ok, 3) TSE – [illegible]." Underneath this note in another handwriting it states MK called after her appointment and complained she had been treated badly. MK also informed Respondent's staff she would be filing a complaint with the Board. MK was charged CPT Code 99243. Respondent's medical record indicates a chief complaint and either a partial physical examination or an assessment. It cannot be discerned what the numbered items are meant to represent – a physical examination or assessment. A good portion of the numbered area is illegible and there is inadequate information describing what MK's lesions looked like and where they were located. There is no identifiable plan of care and no identifiable history of present illness other than MK has had dark spots on her lips for seven years.

17. MK's complaint stated she was not told of Respondent's solvent sensitivities; she signed the statement informing her Respondent was sensitive to solvents and circled that she had on hair spray and perfume the day of her appointment; because of the hair spray and perfume, Respondent asked if she could leave the door to the examination room open and MK agreed; MK presented to Respondent for a blemish on her lip and a full body check; Respondent came into the examination room with a surgical mask on, looked at MK's lip and asked her to hold her arms out, turn them over, and stand; Respondent then ripped the gown down and instructed MK to turn around and then said everything was fine; Respondent then told MK to not show up at the office again wearing hair spray or perfume; the examination lasted one or two minutes; MK was humiliated in the examination room; and Respondent was hostile and angry.

Formal Interview

18. The Board directed Respondent to SO's complaint and, after Respondent acknowledged she had seen the complaint, asked if she refuted SO's allegations. Respondent then asked for time to read the complaint. Respondent remembered SO and seeing her on the day of her examination. Respondent admitted if SO had any scent on the doors in the examination room were left open. Respondent described the examination she performed on SO as starting with SO's hands, then the forearms, then the face and neck. Respondent then lowered SO's gown a bit to look at the upper chest. Respondent usually looks at the abdomen and then the legs, the feet, and asks the patient to stand on the floor so she can see the entire back. Respondent performed only a visual examination and did not palpate or percuss the patient. Respondent will only palpate a mass. Respondent has the patient write their own past medical history. Respondent agreed there was a need in the chart for family history as it concerns melanoma and skin cancer; that there was a need for social history, but the patient fills this out on the history form; and there was a need for review of systems appropriate to the dermatological diagnosis.

19. In terms of a detailed history the components for 99203 include, among other things, a detailed history, which includes a chief complaint, extended history of present illness, a problem-pertinent review of systems, a pertinent past history, family history, social history that may be directed to the patient's problem; a detailed examination including an extended examination of the affected body area and other symptomatic or related organ systems; and medical decision-making of low complexity. Respondent's chart reflected a chief complaint of skin check, but no history of present illness. Respondent did not document an extended history of present illness; or the problem pertinent to the system review. Respondent did not document the examination she claims to have performed – which was looking SO's entire body over. SO's complained that the examination lasted seconds and nothing in the record supports a detailed

examination that would have taken longer. Respondent claimed SO's complaint was hyperbole on her part because she was angry that she had something that smelled. Respondent's chart does not support CPT code 99203. Respondent declined to agree that all cases before the Board were similar in terms of documentation. The Board then discussed three additional charts with Respondent, highlighting similar deficiencies.

20. Respondent explained the group of complaints as being filed by angry patients who were told not to wear solvents, but came in anyway and then got angry when they got "caught" and want to get back at her. Respondent is not currently practicing medicine.

21. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records do not meet this standard.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); A.R.S. § 32-1401(27)(u) ("[c]harging a fee for services not rendered or dividing a professional fee for patient referrals among health care providers of health care institutions or between these providers and institutions or a contractual arrangement that has the same effect.

This subdivision does not apply to payments from a medical researcher to a physician in connection with identifying and monitoring patients for a clinical trial regulated by the United States food and drug administration.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Letter of Reprimand for failure to maintain adequate medical records, charging a fee for services not rendered, and ongoing behavior issues that adversely affect patient care.

2. Respondent is placed on probation for one year with the following terms and conditions:

a. Respondent shall immediately obtain a treating psychiatrist approved by Board Staff and remain in treatment with the psychiatrist for a minimum of twelve months. Respondent shall comply with the psychiatrist's recommendations for continuing care and treatment. Respondent shall instruct the psychiatrist to submit quarterly written reports to the Board regarding continued care and treatment. The reports must be submitted on or before the 15th day of March, June, September and December of each year. Respondent shall provide the psychiatrist with a copy of this Order. Respondent shall pay the expenses of psychotherapy and shall pay for the preparation of the quarterly reports. After twelve months Respondent may submit a written request that the Board terminate the requirement that Respondent remain in treatment with the psychiatrist. The Board's decision to terminate will be based, in part, upon the treating psychiatrist's recommendation for continued care and treatment. The Board may require any additional testing or evaluation necessary for it to determine whether to terminate the therapy requirement.

b. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona.

3. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that she has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 13th day of ~~February~~ April 2007.

ARIZONA MEDICAL BOARD DITAT DEUS 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of ~~February~~ April, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 13th day of ~~February~~ April, 2007, to:

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Cynthia J. Modny, M.D.
Address of Record